Good Ways to Deliver Bad News

By: Curtis Sittenfeld
Wed Dec 19, 2007 at 12:02 AM

Dr. Robert Buckman is a cancer specialist who teaches doctors -- as well as executives at IBM, Andersen Consulting, and Upjohn -- how to break bad news: "You can't let emotions interfere with your message."

The first job of a leader is to be a clear communicator. And one of the toughest challenges for a communicator is to deliver bad news. So leaders who want people to take them at their word in good times had better choose their words wisely during bad times.

Dr. Robert Buckman, 50, has delivered more than his share of bad news. A specialist in breast cancer, he is a medical oncologist at the Toronto-Sunnybrook Regional Cancer Centre and an associate professor in the Department of Medicine at the University of Toronto. The toughest part of his job, he says, is also the most unavoidable part: telling patients that they have a severe, or even fatal, illness. "When I was an intern," Buckman says, "I would see doctors get so embarrassed when they had to give bad news to patients. I thought, 'There must be a protocol that will keep people from having to invent this conversation time and again.'"

The protocol that Buckman developed has caught on. He teaches it to doctors, to medical students -- and to businesspeople, including executives at IBM, Andersen Consulting, and Upjohn. "Begin a difficult conversation by listening," he says. "And end it by summarizing: Review the ground you've covered, identify a plan, agree on a 'contract' for the next contact."

Serious stuff. But Buckman is also a very funny man. At Cambridge University, he was a member of Footlights, a renowned theater revue. He has appeared as a regular in TV series in England and in Canada, and he has worked with John Cleese, of "Monty Python" fame, on a video series for patients. His 10th book, to be released this month, is titled Not Dead Yet: The Unauthorized Autobiography of Dr. Robert Buckman (Doubleday Canada). "That word, 'unauthorized,' seems to increase sales," he deadpans.

Buckman recently sat down with Fast Company to deliver some of his ideas about delivering bad news.

**Start by listening, instead of talking.**

Don't just "get right down to business." Start with a few open-ended questions: "How are you feeling?" "How's it going?" And when the other person is talking, be quiet. The trust that you can build just by letting people say what they feel is incredible.

Eventually it will be time for you to talk. Get your eyes on the same level as the other person's eyes. Look relaxed. And when you respond, use a word or phrase from the other person's last sentence. That kind of repetition signals, "I heard what you said."
Explore perceptions before you try to define reality.

Let's say I'm your boss and I have to give you a rotten performance review. I might say, "Let's start with your telling me what you think of your first year here."

You might say, "I've done pretty well."

I'd say, "Tell me what you mean by 'pretty well.' Are there any problem areas?"

You might say, "Apart from the time I threatened the CEO with a knife, no."

Now comes the hard part. I'd say, "My job is to tell you what it says in your review. And your supervisor reports that it wasn't such a good year." I have to deliver that news. How I do it should reflect my understanding of what you perceive: How well do you comprehend the situation? Are there mismatches between perception and reality?

Legitimize emotions.

Bad news comes with very strong emotions -- and you must always acknowledge those emotions.

I once had a patient who had treatment for ovarian cancer. Sadly, as often happens, her cancer came back a few years later. I had to give her the news, and she reacted in a way that was as dramatic as any I've ever seen. She literally threw herself around the room. I didn't feel calm, but I tried to look calm. I kept offering an empathic response: "This must be absolutely awful." That made her feel that she was in a safe place.

But don't get emotional yourself.

A good, empathic response acknowledges not only someone's feelings but also the reasons for those feelings. It legitimizes emotions in two ways: as a response to the situation, and as an item on the conversational agenda. But you can't let those emotions interfere with your message. If you've got to fire somebody, you can't not fire him because he's crying. But you do have to acknowledge his distress: "I'm making you cry. This must be awful for you."

Sidebar: Ways to Receive Bad News

Dr. Robert Buckman hasn't just delivered bad news. He's received it as well. About 20 years ago, Buckman developed an autoimmune disease called dermatomyositis (it's similar to rheumatoid arthritis). The experience taught him lessons about life and death -- and about the right way to interact with his patients.

Two of the doctors who treated Buckman communicated with him in very different ways. "My gastroenterologist was quite wonderful," Buckman says. "He told me, 'Rob, you've got this thing in your joints, you've got this problem with your nerves, you've got inflammation of the muscles. All of
this must be absolutely awful for you. I'm so sorry.' I almost sobbed with relief. He was not really known for his empathy, but he gave me permission to feel rotten."

Four months later, Buckman met with his primary physician. "I was going downhill rapidly," he says. "My doctor thought I was going to die. But he couldn't abide the pain of telling me. So he called in my then-wife and told her. She came down to my room. She was bright red around the eyes. I said, 'Does he think I'm going to die?' She said, 'He thinks you might.' I had so many questions, but my wife couldn't begin to answer them. This doctor was a good friend, so I understand what he was going through."

Eventually Buckman did respond to treatment, and he hasn't needed to take medication for his condition since 1982. What did he learn from being on the receiving end of bad news? "I realized that I could stay intact psychologically even under the threat of death," he says. "Because of that, I became a braver person."

You can reach Robert Buckman by email (drbuckman@sympatico.ca).

How to Deliver Bad News and Still Look Good
by Patricia Fripp, CSP, CPAE

In every association executive's life the day will come when you must deliver bad news. Sometimes you have to tell the bad news to your Board; every so often you have to tell your membership; periodically you must tell your superior. But whoever is on the receiving end of the message, the way you deliver the news can determine how the messenger (you) is treated.

An example of "bad news" having to do with money was handled in an exemplary way a few years ago by the National Speakers Association. According to Barbara Nivala, the then Executive Vice President of the organization, "we wanted to take a long term approach, upgrading the membership and projecting a higher visibility in the meetings industry. To do this, we felt we had to double the membership dues." No one was happy about that, but the president of the NSA, Tom Winniger, approached the problem by calling the dues increase a "restructuring of dues."

That was just a small part of his approach. First, Tom gave the entire upgrading process a name; he called it "NSA 2000." He alerted the membership through the association mailings that he had many plans for "NSA 2000." He sent out quarterly updates to keep everyone informed and to keep the association moving forward.

Meanwhile, he was working with the NSA staff, past presidents and current leadership to make sure they would buy into his ideas of upgrading the association. He sent "update" notices to his board members, letting them know about progress and problems. He also sought out critics of his ideas and spoke to them individually. He told his own staff that he would personally respond to the negative phone calls and letters, shielding them from irate members.

To insure that the news about the doubling of dues would not hit so hard, Tom saw to it that members received more for their money. He upgraded the newsletter into a classy magazine, making it more than a membership publication. Then he sent it to other industry leaders, creating higher visibility for NSA and its members. He also included taped programs which had previously been sold separately in the monthly mailings.

The result? When "NSA 2000" was presented to the full membership, the doubling of the dues was overshadowed by the benefits. Although individual chapters had a tough time with complaints about the dues, the members did notice an improved image, higher visibility, and more benefits of membership.

The lesson here is that when presenting bad news, always take a long term approach. Trust that your decisions today will have impact for the long term, even if those in power right now may not benefit from it. Every so often you may have to report bad news about something that already happened. The most important part of your approach is to show how you can avoid having the problem again.

If an action has resulted in poor customer service or a financial loss, before you report it, think about what you are going to do so that it will not happen again. When you do have to report the bad news,
have a list of options or solutions ready. You may not have all the answers, but the person you are reporting to doesn't have all the answers either.

If you approach the situation and are up front about it, that will help. If you have to report to a superior, try telling them that you have a situation that is a problem, but you also have some possible solutions. If the person you are talking to understands that you are trying to solve the problem rather than being stuck in it, the meeting will go easier.

If you are successful, you will leave your meeting feeling revitalized because the problem is over and done with, and you have agreed on ways to avoid repeating it in the future.

Larry Wilson, author of *One Minute Salesman*, believes that most business traumas will turn out to be merely inconveniences or even springboards to something better when seen in perspective. Businesses run in cycles, up and down. When you survive a few cycles, you are more valuable to your organization.

Dale Carnegie said it many years ago, "When life hands you a lemon, make lemonade." That lemon you just swallowed can be a springboard for creative thinking and new growth.

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I read an interesting article in the *Omaha World-Herald* last week titled “Future doctors trained to show some heart when giving bad news.” In it the author spoke of the way doctors and medical students are trained to deliver bad news. In a byline a short list of helpful hints were listed that are frequently taught in medical school to educate young trainees on how to best break regrettable news (in the form of the poorly-conceived mnemonic “SPIKE”):

**S is for Setting**  
The setting should be a private place with the door closed or curtains drawn around the hospital bed.

**P is for Perception**  
Perceive the patient's view of the situation by asking something like "What have you been told so far?" or "Are you worried this might be serious?"

**I is for Invitation**  
Invite a discussion. Don't assume the patient wants details. "How much information would you like me to give you about your diagnosis and treatment?"

**K is for Knowledge**  
Before imparting knowledge, warn the patient that bad news is coming. This gives the patient or relative a few seconds to prepare. Say "Mrs. Smith, I'm so sorry to have to tell you . . ." or "Unfortunately, I've got some bad news to tell you, Mr. Andrews."

**E is for Empathy**  
Empathize. Listen for and observe the patient's emotion. Show your patient that you have identified the emotion. Say: "Hearing the result of the bone scan is clearly a major shock to you" or "Clearly, this is very distressing."

**S is for Strategize and Summarize**  
Summarize the information and give your patient a chance to voice concerns or questions. Work out a plan for the next steps that should be taken.

Reading this article reminded me of the absolute worst interaction I’ve ever seen between a doctor and the family of a recently deceased patient. It was several years ago while I was a fellow in cardiovascular medicine. The senior physician I was assisting had just unsuccessfully attempted to open a blocked vessel in a relatively young woman with a heart attack. We pulled the family members into a room and he proceeded to give them the news. It went something like this:

**Doctor:** I’m afraid I have some bad news. Please sit down.

**Husband:** What is it? What happened? Is she going to be okay?
**Doctor**: The coronary lesion was complex and ulcerated and we couldn’t get the wire to pass through the lumen. She developed a dissection flap and occluded flow to a large part of her myocardium.

**Husband**: Is she all right?

**Doctor**: We tried to place a balloon pump to support her perfusion but her pressure kept dropping. We had her on several pressors and I think that may have contributed to her arrhythmia.

**Husband**: What do you mean by arrhythmia? Is she okay? Can we see her?

**Doctor**: We—the whole staff—did everything we could but I’m afraid we couldn’t resuscitate her.

**Husband**: Resuscitate her? What does that mean?

**Doctor**: Well, we lost her.

**Husband**: Lost her? What are you saying? Are you saying she died?

**Doctor**: You have to understand that she had already suffered a lot of damage even before she got to the emergency room.

**Husband**: Did she die?

**Doctor**: Well, . . . yes.

I don’t think I need to point out all the ways in which the doctor messed up this delicate encounter. It’s pretty clear to me that my esteemed mentor must have missed the day in doctor school when they taught this lesson. I don’t think he could have done a worse job.

When delivering news about a death, the only advice I could add to that given in the *World-Herald* article is this: Deliver the news in plain, simple, direct language (“I’m sorry to say that your mother has died”). Don’t use euphemisms (“we lost her,” “she has passed,” “she’s not with us anymore”) or technical language. Just come out with it. I also don’t think it’s helpful to go into much detail about the events leading up to the death since most families won’t hear another word you say after you’ve told them the news. There will be time later for this.

I can still remember the way I felt as I sat in the room listening to the senior cardiologist deliver his obtuse report. I was sick to my stomach and wanted to either slink out of the room or strangle him. I did neither, but I did apologize later to the family and I think it helped. And I did it in plain English.

*Preluat de pe*: http://blogalegent.com/Cardiology-Blog-Delivering-Bad-News
How to Deliver Bad News
By eHow Relationships & Family Editor

Breaking bad news is difficult, painful and often awkward. This strategy helps make the task more effective and a bit easier. What matters most is not how you deliver the bad news, but how you listen and respond with compassion afterward.

Instructions

1. Step 1

Choose a comfortable setting where you both can sit. Create an air of privacy by closing the door, turning off the television and eliminating distractions.

2. Step 2

Assess the other person's feelings. Does she appear worried, upset and suspicious? Does she anticipate this news or will it come as a total surprise?

3. Step 3

Choose your words based on your relationship with the individual as well as your personal style. If the news is unexpected, say, "I'm afraid I have some news about . . . " or "I've just heard from the hospital."

4. Step 4

Identify with the emotions that arise. For example, you might say, "It must be a terrible shock for you" or "I'm sure this is painful for you."

5. Step 5

Listen to the other person; let him talk. Validate their emotions, but primarily listen and acknowledge.

6. Step 6

State what you are prepared to do to help, rather than ask, "What can I do?" Make a reasonable plan. Be clear about your commitment and fulfill your promises.

Tips & Warnings

- Avoid "I know just how you feel," even if you have experienced something quite similar.
- Do not share your experiences in an effort to be empathetic.

The difficult task of ... delivering bad news

The dying need the friendship of the heart - its qualities of care, acceptance, vulnerability, but also need the skills of the mind - the most sophisticated treatment that medicine has to offer. On its own, neither is enough. *Dame Cicely Saunders (Kuhl, 2002)*

No one likes to be the bearer of bad news. However, breaking bad news is part of the health care team's job.

The medical field tends to focus on a "cure" model of treatment, creating a situation where the comfort level of most health care providers is very low when it comes to delivering bad news to a patient. This delivery is very important, a legal obligation, and takes skill. Fortunately, the skills needed in such circumstances can be learned.

An expert in breaking bad news is not someone who gets it right every time - he or she is merely someone who gets it wrong less often and who is less flustered when things do not go smoothly.

The Process

Bad news is any news that drastically and negatively alters the patient's view of his or her future. The "badness" of bad news is the gap between the patient's expectations and the medical reality.

The process of delivering bad news starts before the diagnosis is made, and much depends on how well the nurse and other providers have prepared the patient for the possibility of a bad outcome. When the first test is ordered there should be a straightforward dialogue with the patient regarding all possibilities. These discussions open the paths of communication and lay a foundation of trust and understanding between the provider, nurse, and patient.

In ambulatory care settings, the nurse should be included throughout this process. When the doctor is busy, the nurse may be able to have an open discussion with the patient to answer questions and respond to concerns and fears the patient has regarding health issues. The nurse and doctor need to work together to meet the patient's needs.

Communicating Effectively

Good communication in the health care setting is not always an easy task. There are many distractions, interruptions, and time demands that can interfere. If we do not do the work of communicating, we usually find ourselves at odds with an upset patient.

There are several basic communication strategies (see Table 1, next page). Start by preparing to listen. Sit down, give the patient your full attention, make eye contact, and look relaxed. This sounds time consuming but takes no more time than standing at the door with one hand on the knob, while glancing at your watch while the patient asks a question. The hurried appearance of the provider can cause the patient not to ask questions they need answered, and patient satisfaction is greatly increased when the provider appears unhurried.
The nurse can help collect information by interviewing the patient during his/her visit. The nurse should ask questions while keeping in mind the following: closed questions are good for collecting demographic data; open questions require the patient to respond with more than a yes or no answer. This can help determine what the patient wants to know, what is worrying him/her most, and what he/she already knows.

Getting the patient to talk is an important part of the process but it is only the beginning. The nurse needs to listen and validate what she thinks the patient said. We tend to color what others say with our own experiences and feelings, so nurses need to be aware that this may totally change the meaning of what the patient was trying to say. Be sure to repeat and reiterate your interpretation of the conversation to assure you understand what the patient actually said.

Respond to the patient's feelings by answering questions. Try to identify expressed emotions and feelings, find their causes, and acknowledge them.

Nurses should also observe nonverbal cues. For example, the patient may not say "I'm angry" but the nurse perceives anger in his/her body language and tone of voice. This needs to be acknowledged. The nurse could say "I think I would feel very angry if I were in your situation. How are you dealing with your feelings of anger?" This removes any judgmental or negative connotations associated with anger and sets the emotion forth as normal and expected. The patient and caregiver can deal more effectively with each other and issues related to the patient's health if underlying emotions have been acknowledged, discussed, and accepted.

**The Six-Step Protocol for Bearing Bad News**

The six-step protocol is summarized in Table 2 (next page). The following explains details of the method:

Start well. Be sure to get the physical context right. Consider the location -- is it a comfortable environment and does it provide privacy? Decide as a team whom to include: the primary doctor, who should take the lead; the nurse who has developed a good working relationship with the patient; and family members or friends chosen by the patient. The nurse can facilitate the logistics of the meeting and make sure all are able to be present.

Find out how much the patient knows. If this information has not been ascertained in prior discussions, it is important to know what information (or misinformation) the patient may have. Much anxiety comes from partial truths and false information.

Find out how much the patient wants to know. In the 1950s and 1960s, doctors as a rule felt it inappropriate to tell their patients the whole truth. The common thought was the patient doesn't want to know. Recent studies show that 50% to 97% of patients want to know the truth about their illness, even when dealing with bad news (Buckman, 1992).

Share information. Set an agenda that includes crucial objectives such as specifying the diagnosis and explaining it in terms the patient can understand. Include the treatment plan and be sure to allow the
patient to make choices when possible. Give realistic pros and cons to the options. Discuss the prognosis including what the patient can expect as realistic outcomes. Do not give false hope; remember that while it can be painful, most patients want to know the truth. Truth is like a drug that has its own pharmacology - insufficient doses are ineffective and may harm the patient's trust in the provider; overenthusiastic dosing may cause symptoms of overdose. The manner in which truth is shared may be a significant predictor of the patient's response to the bad news (Garrett, 1998).

Also, make sure to provide support to the patient. This takes many forms, from offering immediate comfort through a compassionate touch to discussing symptom management and resources for support groups that are available.

Start from the patient's starting point - you don't want to be redundant by giving information the patient already knows but you also should not assume the patient has knowledge by virtue of having the disease.

In addition, keep in mind that patient education is best given in small chunks. A patient who is receiving all the information at once may feel overwhelmed and not be able to digest all of it. Schedule revisits for this purpose and remember to use language that is easy to understand rather than medical jargon. While jargon is a very comfortable hiding place for the health care provider it rarely communicates and can be a source of great anxiety for the patient. Check frequently to see how the patient is receiving the news - how is he/she reacting? Reinforce and clarify, have the patient restate what you have told him/her to validate understanding. Listen for the patient's agenda and discuss the topics that seem to be of utmost concern.

Respond to the patient's feelings. Identify and acknowledge the patient's reactions to the bad news. Validate these feelings: they are neither right nor wrong, they just are. Help the patient begin to accept these feelings.

Plan and follow-up. Make an agreement with the patient regarding the treatment plan and follow through with it. Reassess the plan's validity with the patient on a regular basis and revise as necessary. The patient has a right to make care decisions for him or herself. We may not agree with the decision but must respect and support the patient's right to make choices, especially when a cure is not an option.

**Conclusion**

This is not the end of the story for the patient. Throughout the process from diagnosis and treatment to death, we must strive to meet the patient's needs. Not just physical but spiritual and psychosocial. Maintaining straightforward communication with the patient and family regarding all possibilities lays a foundation of trust and understanding between the patient and the health care team. In this kind of setting the patient is more likely to receive comfort measures and palliative care at the appropriate time in the process not as a last resort or an after-- thought to care.
As nurses, we must help the patient to a kinder and more compassionate end of life experience. While technology provides more opportunities for better outcomes than ever before, there comes a time when more is not better but gets in the way of the patient's ability and need to say goodbye.

References:


Resources:


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